

065181 SEP 10 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

87

26612

1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN I. ANDERSON</b>			2a. DATE OF DEATH MONTH <b>9</b> DAY <b>5</b> YEAR <b>87</b>		2b. HOUR <b>11</b> <sup>PM</sup>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>30</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b> YRS.	IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MD</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>		
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager-MD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Casualty</b>
13a. STATE <b>MD</b>		13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Ellicott City</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>J.</b> MIDDLE <b>Fred</b> LAST <b>Anderson</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Launa</b> MIDDLE <b>A.</b> LAST <b>Henning</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212 10 3699</b>		17. INFORMANT <b>Donothy Lang, Ellicott City, MD</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Renal Failure, Acute**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Acute - Days**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Pneumonia****WEEKS**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Atherosclerotic Cardiovascular Disease.**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>8/28/87</b> 19 <b>87</b> , to <b>SEP 5</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>SEP 5</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If first (last) (did not) view the body after death.)			
22b. SIGNATURE <b>J. A. Jenkins</b>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>9-5-87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JERRY I. LEWIS, MD</b>		22e. ADDRESS <b>11055 Little Patuxent Pkwy, Columbia, Md.</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>9/11/87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley</b>	23d. LOCATION CITY OR TOWN <b>Balto. County</b> COUNTY <b>MD</b> STATE
24. FUNERAL DIRECTOR NAME <b>A.W. Jenkins &amp; Sons Co. 21212</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 9 1987</b> 25b. REGISTRAR'S SIGNATURE <b>J. A. Jenkins</b>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and advised.)

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

062101 SEP 10 87

11 087 9  
11 087 9  
11 087 9

11 087 9  
11 087 9  
11 087 9

11 087 9  
11 087 9  
11 087 9

11 087 9  
11 087 9  
11 087 9

11 087 9  
11 087 9  
11 087 9

066865 SEP 25 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

26613

REG. 110.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR					
Jacqueline S. Bartles						7 27 1987						M					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR			
FEMALE		WHITE		JUNE 25, 1967		20 YRS.						7 27 1987		225 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND				U.S.A.								Howard County, MD					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
ELLCOTT CITY				Route 29 at junction at Rt. 103				SPEC. 4				U.S. ARMY					
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?					
Md.				WASHINGTON				HAGERSTOWN				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS				13f. WEST SIDE AVE.					
CLYDE R. BARTLES				LINDA V. RIDGE				39				21740					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
YES				ACTIVE DUTY				220-94-7796				CLYDE R. BARTLES (SAME AS ITEM #13)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																	
IMMEDIATE CAUSE (a) Multiple Injuries																	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																	
(b)																	
DUE TO, OR AS A CONSEQUENCE OF																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
				11:50x 7- 27 1987				Passenger of auto/auto collision									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION				21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
				road				Rt. 29 at junction at Rt. 103				Howard		MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED									
Margarita A. Korell				M.D. Assistant				7-27-87									
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Margarita A. Korell, M.D.				111 Penn St., Balto. Md. 21201													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION					
BURIAL				AUG. 1, 1987				BOARD FORDING CEMETERY				HAGERSTOWN, WASH. CO., Md.					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
W. W. CHAMBERS CO.				RIVERDALE, Md. 20737				AUG 4 1987				Julia Davidson-Randall					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

060300 205932 22

• • •

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH - 1650M 1/76  
(VR A 15 (4))

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										26014	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH DAY YEAR		2b. HOUR			
DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHENNELLE ANYA BLACKWELL			9/28/87		11:52 P.M.						
3. SEX Female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 9 28 87		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 1 16					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD MD					
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. Gen. Hos.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b. KIND OF BUSINESS OR INDUSTRY NONE					
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Woodlawn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3117 BELTOW-JAMES PL, BALT.			
14. FATHER'S NAME FIRST MIDDLE LAST ELMER BLACKWELL		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TRACY BLACKWELL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Woodlawn, Md. 21207 Elmer Blackwell 3117 Beltow James Place			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurely, self-he DUE TO, OR AS A CONSEQUENCE OF (b) should self-he DUE TO, OR AS A CONSEQUENCE OF (c) failure.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.											
22b. SIGNATURE Aruna Khurana		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10.1.87					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) *ARUNA KHURANA, M.D.		22e. ADDRESS 10804 HICKORY RIDGE RD, COLUMBIA		22f. ADDRESS 21044							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/2/87		23c. NAME OF CEMETERY OR CREMATORY Md. National Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md.					
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045				25a. DATE REC'D. BY REGISTRAR OCT 05 1987		25b. REGISTRAR'S SIGNATURE Kendall-Randall					

087874 OCT-80



x



067557 OCT-5 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26615

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) C. Howard BOCKOVER			2a. DATE OF DEATH MONTH DAY YEAR 9 29 87		2b. HOUR 1:18 P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR July 20, 1908	6 AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10 CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Howard Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auditor	12b. KIND OF BUSINESS OR INDUSTRY Real Estate	
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD 13b COUNTY Howard 13c CITY OR TOWN Ellicott City 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 3335 N. Chatham Rd., 21043		
14 FATHER'S NAME FIRST MIDDLE LAST Clarence Bockover			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Emma Howard		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 216.05 4712	17 INFORMANT ADDRESS Mrs. Margaret Bockover, Same		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9-28</u> , 19 <u>87</u> , to <u>9-29</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9-29</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Krishna P. Kumar</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9-29-87</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KRISHNA P. KUMAR</u>		22e. ADDRESS Howard County General Hospital, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	23b. DATE <u>10/2/87</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto., MD</u>	
24 FUNERAL DIRECTOR NAME <u>H.W. Jenkins &amp; Sons Co.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 2 1987</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rudolph</u>	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

061283  
061283



FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
Maude		Marie		Bohnet				Sept. 9-6-87					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		9. DATE PRONOUNCED DEAD	
Female		White		Feb. 11 1909		78 YRS.		MONTHS DAYS		HOURS MIN		September 6, 1987 2:00 PM	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		11. CITIZEN OF WHAT COUNTRY?		12. MARRIED		13. NEVER MARRIED		14. WIDOWED		15. DIVORCED		16. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.		<input type="checkbox"/>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Howard County MD	
17. CITY OR TOWN OF DEATH		18. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		19. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)		20. KIND OF BUSINESS OR INDUSTRY							
Ellicott City		Rt. 70 and 29, East Lane of 70		Packer		Glass Co.							
21. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		22. STATE		23. COUNTY		24. CITY OR TOWN		25. INSIDE CITY LIMITS?		26. STREET ADDRESS			
Maryland		Baltimore		Balto. Highlands		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3018 Ohio Ave.		21227			
27. FATHER'S NAME (FIRST MIDDLE LAST)		28. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		29. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		30. SOCIAL SECURITY NO.		31. INFORMANT		32. ADDRESS			
Robert H. Walker		Addie Craft		None		212.22.1463		(Son) Clarence L. Dilday		108 Charles Road			
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		34. PART I DEATH WAS CAUSED BY:		35. IMMEDIATE CAUSE (a)		36. DUE TO, OR AS A CONSEQUENCE OF		37. (b)		38. DUE TO, OR AS A CONSEQUENCE OF		39. (c)	
8121		Multiple injuries											
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b),													

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**NOTES TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE COMPLETE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM JM-1. RETAIN PAGE 5 FOR YOUR FILES.

**NOTES TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BOSTON, MASSACHUSETTS 02112. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BOSTON, MASSACHUSETTS 02112. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. BOSTON STREET, BOSTON, MASSACHUSETTS 02112.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

082380 SEP 14 81



RECEIVED NOTED FOR

DAVID M. WILSON

SEP 10 1981

065321 SEP 14 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Catherine A. Boyd

## CERTIFICATE OF DEATH

REG. NO.

26617

1. DECEASED NAME (TYPE OR PRINT) Catherine Boyd			2a. DATE OF DEATH MONTH DAY YEAR 09-07-87			2b. HOUR 9:10 P.M.			
3. SEX female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06-09-82		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Extended Care				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Essex		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2122 Riverview Road 21221		
14. FATHER'S NAME FIRST MIDDLE LAST Alan Skeen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Donnelly							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-30-5624		17. INFORMANT Joseph Langstrom				ADDRESS 2120 Riverview Rd. 21221			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>anemia</u> DUE TO, OR AS A CONSEQUENCE OF - (b) <u>metastatic uterine sarcoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7/87</u> <u>12/86</u>	
---	--	--	--

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>S/P radiation therapy, S/P TAH+BSOP</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>8/29/86</u> to <u>9/7</u> , 19 <u>87</u> that (1) (we) last saw the deceased alive on <u>9/7</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Kolodrubetz</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KOLODRUBETZ, Richard.		22e. ADDRESS Suite 103 2850 N Ridgely Rd Ellicott City MD 21048					

23a. BURIAL, CREMATION, REMOVAL (1) BURIAL		23b. DATE 9/10/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR Kruzdinski Funeral Home PA 1407 Old Eastern Ave				25a. DATE REC'D. BY REGISTRAR SEP 10 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified of the same.

062351 158200

066911 SEP 23 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26018

1. DECEASED NAME (TYPE OR PRINT) <b>LILLIE Maude BROWN E</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 22 87</b>			2b. HOUR <b>3-10 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 10 03</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD.</b>		13b. COUNTY <b>A.A.</b>		13c. CITY OR TOWN <b>Hanover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6952 Ridge Rd., Hanover, Md. 21076</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph L. German</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Sherwood</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-28-1187</b>		17. INFORMANT <b>Clifford A. Browne</b>		ADDRESS <b>6950 Ridge Rd., Hanover, Md. 21076</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardio respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dehydration</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Leaking Gastrostomy Site</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 weeks</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Seizure.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-1-87</b> to <b>9-22-87</b> , that (I) (we) last saw the deceased alive on <b>9-22-87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Krishna P. Kumar</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9-22-87</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KRISHNA P. KUMAR</b>				22e. ADDRESS <b>10802 Hickory Ridge Rd., Columbia</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Sept. 25, 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Howard Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Gary L. Kaufman,</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson</b>			

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

1-1-77

2000

3000

0

1000

2000

3000

1000

2

1000

2000

1000

1000

1000

1000

1000

2

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

065766 SEP 18 87

FOR  
STATE  
REGISTRAR

LUCY CABRIJAN

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 9/14/87

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lucy Cabrijan</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>9/14/87</b>		2b. HOUR <b>6:08 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 4, 1915</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>TRINIDAD, WEST INDIES</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE'S AIDE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HEALTH</b>			
13a. STATE <b>NEW YORK</b>		13b. COUNTY <b>KINGS</b>		13c. CITY OR TOWN <b>BROOKLYN</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>UNKNOWN ROMANY</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARZEE UNKNOWN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>068-42-4476</b>		17. INFORMANT <b>GLORIA ROJAS</b>	
				ADDRESS <b>961 VICTORY BLVD. STRATEN ISLAND, N.Y. 10301</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Ventricular Tachycardia</b>		<b>1 hour</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Ischemic Cardiomyopathy</b>		<b>5 yrs</b>

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **Sepsis**

19a. DATE OF OPERATION <b>9/14</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Necrosis of both lower extremities</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 23, 1987</b> to <b>Sept 14, 1987</b> that (I) (we) lost saw the deceased alive on <b>Sept 13, 1987</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David Jackson</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/14/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAVID JACKSON</b>				22e. ADDRESS <b>11055 Little Patuxent Parkway Columbia, MD 21044</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>9/15/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WESTVIEW CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>CATONSVILLE MARYLAND</b>	
24. FUNERAL DIRECTOR <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES P.A.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1987</b>			
5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045				25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



10 31 93 667 201

067025 SEP 29 87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26620	
1- STATE REGISTRAR										2- DATE KNOWN OF DEATH	
3- DECEASED NAME (PRINT) FIRST MIDDLE LAST CARL O CARLSON										DATE KNOWN OF DEATH ESTIMATED 9-25-87	
4- SEX Male										5- RACE White	
6- DATE OF BIRTH (MONTH DAY YEAR) Oct 2, 1927										7- AGE (IN YEARS) (LAST BIRTHDAY) 59 YRS.	
8- IF UNDER 1 YR. IF UNDER 24 HRS.										9- DATE PRONOUNCED DEAD 9-25-87	
10- BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington										11- CITIZEN OF WHAT COUNTRY? U.S.A.	
12- MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										13- BALTIMORE CITY OR COUNTY OF DEATH Howard County	
14- CITY OR TOWN OF DEATH Ellicott City										15- NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3009 Rogers Avenue	
16- USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										17- KIND OF BUSINESS OR INDUSTRY	
18- USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										19- ADDRESS	
20- STATE Maryland										21- COUNTY Howard	
22- CITY OR TOWN Ellicott City										23- INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
24- FATHER'S NAME FIRST MIDDLE LAST Carlson										25- MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edith	
26- WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes Korean										27- SOCIAL SECURITY NO 534 22 7005	
28- INFORMANT ADDRESS Mrs Nancy C Carlson 3009 N Rogers Ave 21043										29- DATE OF OPERATION	
30- CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1										31- DATE OF OPERATION	
32- CONDITION FOR WHICH OPERATION WAS PERFORMED?										33- AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
34- EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										35- TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 9-25-87	
36- INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK										37- HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject found hanging in a closet	
38- PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) basement										39- LOCATION CITY OR TOWN COUNTY STATE 3009 Rogers Avenue Ellicott City, Maryland	
40- I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										41- ACTUAL SIGNATURE Ann M. Dixon, M.D.	
42- TITLE (SPECIFY) Assistant										43- DATE SIGNED 9-26-87	
44- ADDRESS 111 Penn Street										45- EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.	
46- BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										47- DATE Sept 29 '87	
48- NAME OF CEMETERY OR CREMATORY Garrison Forest Veterans										49- LOCATION CITY OR TOWN COUNTY STATE Garrison Forest Balto. Md.	
50- FUNERAL DIRECTOR NAME Harry H Witzke										51- ADDRESS 4112 Old Columbia Pike Ellicott	
52- DATE RECD BY REGISTRAR SEP 28 1987										53- REGISTRAR'S SIGNATURE [Signature]	

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))

081052 SEP 59 81



SEP 28 1959

065389 SEP 14 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26021

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH DAY YEAR			2b. HOUR							
Alice Frances Casper						Sept. 6, 1987						M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) (LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		2d. HOUR					
Female		White		Oct. 25, 1933		54 YRS.						September 6, 1987		2:00P					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED WIDOWED				9. BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina				U.S.A.				NEVER MARRIED DIVORCED				Howard County MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Ellicott City				Rt. 70-East Lane and Rt. 29				Beautician				Self. Emp.							
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS?				13e. STREET ADDRESS			
13a. STATE												13b. COUNTY				13c. CITY OR TOWN			
Maryland												Anne Arundel				Glen Burnie			
14. FATHER'S NAME												15. MOTHER'S MAIDEN NAME							
Jerome Dilday												Maude M. Walker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS							
No				None				213.30.4723				(Daughter) 3012 Ohio Ave. Dawn M. Schanne Balto. Md. 21227							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) Multiple injuries																			
DUE TO, OR AS A CONSEQUENCE OF																			
(b)																			
DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
				1:00PM 9-6-87				Passenger of auto/auto/collision											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION											
				road				Rt. 70 East Lane and Rt. 29, Ellicott City, Howard County, MD											
22a. I certify that I took charge of the remains described above, field on death resulted from												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/>				TITLE (SPECIFY)			
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE												DATE SIGNED							
Dennis F. Smith, M.D.												9-7-87							
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS							
												11 Penn Street, Balto., MD 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION							
Burial				Sept. 11, 1987				Cedar Hill Cemetery				Brooklyn Pk. A.A. Co. Md.							
24. FUNERAL DIRECTOR												25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Singleton Funeral Home Glen Burnie, Md.												SEP 10 1987				Julia Davidson-Rudolph			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. (SEE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP

DHMH - 17  
(VR A15 ME (5))

062388 SEP 14 87



SEP 14 1987

STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

 FOR  
 1- STATE  
 REGISTRAR

DECEASED NAME (TYPE OR PRINT) <b>GABRIEL JOSEPH CHICONE</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9 23 87</b>		2b. HOUR <b>1149 P.M.</b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JAN. 23 1905</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD</b> MD		
10. CITY OR TOWN OF DEATH <b>LAUREL</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8706 Yellowbird Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>	13c. CITY OR TOWN <b>LAUREL</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>LOUIS CHICONE</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ANGELA TANTULLO</b>		13e. STREET ADDRESS / ZIP CODE <b>8706 YELLOW BIRD COURT 20707</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES] <b>NO</b>		16b. SOCIAL SECURITY NO. <b>706-82-8098</b>		17. INFORMANT <b>MARIANNE CHICONE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>SUSPECTED MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ANGINA</b> YEARS (c) <b>CORONARY ARTERY DISEASE</b> YEARS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>DIABETES, TRANSITIONAL CELL CARCINOMA BLADDER</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on above, (I) (we) did (did not) _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE <i>[Signature]</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/23/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ESMACHADO</b>		22e. ADDRESS <b>321 PRINCE GEORGE STREET LAUREL</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>9/26/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Name Cemetery</b>	
23d. LOCATION <b>Jersey City Hudson N.J.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Fleck Funeral Home, Inc. Laurel, Md. 20707</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 01 1987</b>			
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

195-100-07173

195-100-07173



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 6 6 2 3

REG. NO.

FOR  
1- STATE  
REGISTRAR

2- CEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

KAREN

M.

DAWSON

3. SEX

Female

4. RACE

White

5. DATE OF BIRTH

9-15-56

6. AGE (IN YEARS)

31

IF UNDER 1 YR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. DATE KNOWN  
OF ESTI.  
DEATH MATED

☒ MONTH DAY YEAR  
☐ 9-23-87 19

7b. HOUR  
M

7c. DATE  
PRONOUNCED  
DEAD

9-23-87 19

7d. HOUR  
7:35P

7a. BIRTHPLACE (STATE OR  
FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Howard County

MD

10. CITY OR TOWN OF DEATH

Columbia

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION  
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

Howard County General Hospital

12a. USUAL OCCUPATION (TYPE OF WORK  
FOR MOST OF WORKING LIFE)

Engineer

12b. KIND OF BUSINESS  
OR INDUSTRY

A.R.I.N.C.

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

Howard

13c. CITY OR TOWN

Marriottsville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS

1221 Marriottsville Rd.

21104

14. FATHER'S NAME

Robert

MIDDLE

Kurzmilller

LAST

15. MOTHER'S MAIDEN NAME

Nancy

MIDDLE

LAST

Stewart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.  
(IF YES, GIVE WAR OR DATES)

----

212-60-4917

17. INFORMANT

21104 ADDRESS

ville Rd.

Mr. Charles L. Dawson III 1221 Marriotts-

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I DEATH WAS CAUSED BY:

8120

Conditions, if any, which  
gave rise to immediate  
cause (a) stating the under-  
lying cause last.

IMMEDIATE CAUSE (a) Multiple injuries

DOE TO, OR AS A CONSEQUENCE OF

(b) DOE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☒ OR  
CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

5:45PM 9-23-87

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

driver of an auto/auto impact

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☒  
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,  
STREET, FACTORY, FARM, ETC.)

intersection of

21f. LOCATION

Marriottsville Rd. & Md. Rt. 99 Howard Co., Md.

22a. I certify that I took charge of the remains described above, held an autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion  
death resulted from Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐.

ACTUAL  
SIGNATURE

*Dennis F. Smyth*

TITLE (SPECIFY)

Assistant MEDICAL EXAMINER

DATE  
SIGNED

9-24-87

EXAMINER'S NAME  
(TYPE OR PRINT)

Dennis F. Smyth, M.D.

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Cremation

23b. DATE

9-25-87

23c. NAME OF CEMETERY OR CREMATORY

Westview Crematory

23d. LOCATION  
CITY OR TOWN

Catonsville

COUNTY

Baltimore

STATE

MD

24. FUNERAL DIRECTOR

NAME

Loring Byers Funeral Directors, Inc

ADDRESS

8728 Liberty Rd. Randallstown, MD 21133

25a. DATE REC'D. BY REGISTRAR

SEP 25 1987

25b. REGISTRAR'S SIGNATURE

*Davidson-Randall*

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3. RETAIN PAGE 5 FOR YOUR FILES.  
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET,  
BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25M

BP  
DHMH - 17  
(VR A15 ME (5))

9 8 2 3 3 2 8 3 8 3

20% COTTON 18ER

WATER

J65167 SEP 10 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26624

1- STATE REGISTRAR KATHARINE DONAHAY		2a. DATE KNOWN OF DEATH MONTH DAY YEAR 9-6-87		2b. HOUR 8A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 22, 1892	
6. AGE (IN YEARS) 95 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD		10. CITY OR TOWN OF DEATH COLUMBIA	
11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD COUNTY GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SCHOOL TEACHER		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION	
13a. STATE MARYLAND		13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA	
14. FATHER'S NAME FIRST MIDDLE LAST PATRICK DONAHAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET O'CONNELL		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 578-54-3612		17. INFORMANT KEVIN BUSH		ADDRESS MD. 21045 6587 PRESSED GENTIAN COLUMBIA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 887 IMMEDIATE CAUSE (a) <u>Cerebro-vascular event</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>C.V.A. - Fracture of femoral shaft</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>long urinary tract infection</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 weeks					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE Robert L. Budicke		TITLE (SPECIFY) M.D.		MEDICAL EXAMINER DATE SIGNED 9-6-87	
EXAMINER'S NAME (TYPE OR PRINT) Robert L. Budicke		ADDRESS 7055 Chevrolet Rd. Ellicott City, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/12/87		23c. NAME OF CEMETERY OR CREMATORY ST. MARY'S CEMETERY	
23d. LOCATION CITY OR TOWN LOCH HAVEN		COUNTY PENNSYLVANIA		STATE	
24. FUNERAL DIRECTOR NAME LEROY M. & RUSSELL C WITZKE FUNERAL HOME		24b. DATE REC'D BY REGISTRAR SEP 9 1987		24c. REGISTRAR'S SIGNATURE D. J. Anderson	
1630 EDMONDSON AVE. CATONSVILLE MD 21228					

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, AND 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1, 2, AND 3. RETURN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH-17  
(VR A15 ME (5))  
15M 7/77

102187 SEP 10 07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
REGISTRATION  
7-SEP-14-87

26025

1 DECEASED NAME (TYPE OR PRINT) <b>Julia Dunbar</b>			2a DATE OF DEATH MONTH DAY YEAR <b>9-8-87</b>			2b HOUR MIN. <b>2 A</b>					
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 12 30</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>66</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>US</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD					
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lorien r.H</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>- Domestic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>-</b>			
13a STATE <b>md.</b>			13b COUNTY <b>Howard</b>		13c CITY OR TOWN <b>Columbia</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>6927 Carlinda Avenue 21046</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Peter Long</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Jones</b>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO. <b>248-58-0765</b>			17 INFORMANT ADDRESS <b>Shelly Boswell 6927 Carlinda Ave., Columbia, MD.</b>					

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Pneumonia**

DUE TO, OR AS A CONSEQUENCE OF

**Severe Rheumatoid arthritis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

19a DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>9/17 1980</b> , 19 <b>80</b> , to <b>9/8/87</b> , 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/17 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <b>William Flowers M.D.</b>				DEGREE <b>M.D.</b>		22c DATE SIGNED <b>9/8/87</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>William Flowers, M.D.</b>				22e ADDRESS <b>11055 Little Patuxent Pkwy Columbia Md.</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-12-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FourMileBaptist Church NewEllentown Aiken, South Caroli</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Marzullo Funeral Service</b>				ADDRESS <b>Upperco, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 10 1987</b>	
				25b. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>			

062317 SEP 14 81

20% COTTON FIBER

WINDMILL BRAND



SEP 10 1981



066825 SEP 25 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26020

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grete Fischer			2a. DATE OF DEATH MONTH DAY YEAR September 19, 1987		2b. HOUR 8:00 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR August 24, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany	7b. CITIZEN OF WHAT COUNTRY? Germany	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD	
10. CITY OR TOWN OF DEATH Woodbine	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Tara Retirement Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own home
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Bethesda	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6304 Allcott Road / 20817	
14. FATHER'S NAME FIRST MIDDLE LAST Karl Weitz		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margarete Bender			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. None	17. INFORMANT ADDRESS Waltraud Schmedtje, Same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>JULY 27</u> , 19 <u>82</u> , to <u>September 19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>August 25</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Frauke Westphal</i>		DEGREE <u>MD</u>		22c. DATE SIGNED 9-19-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frauke Westphal, M. D.		22e. ADDRESS 809 Viers Mill Road, Rockville, MD 20851			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 9-20-87	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Richard Rapp, Inc.		25a. DATE REC'D. BY REGISTRAR SEP 24 1987		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	
P. O. Box 43352, Washington, DC 20010					

MEDICAL CERTIFICATION

29

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copy of pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



000000 22 SEP 52

100% COTTON FIBER

100% COTTON FIBER

SEP 24 1952

FOR  
-5 87 TE  
O REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

26627

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE RETURN THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.

**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL—TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 501 WEST LEXINGTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)		MIDDLE		LAST		REG. NO.		2b HOUR	
RICARDO		FORD				2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 9-27-87 19		2b HOUR	
3 SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	2d HOUR	
Male	Black	12 13 55	31 YRS.	Washington, D.C.	U S A		Howard County	6:55P	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Northbound Rt. 29 just N. of Rt. 32 entrance				Military			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS		3928 - 14th Street, NW.		
D. C.		N/A	Washington						
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Richard B Ford		Mildred Frey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Yes		4/6/78 - 3/13/83 578-74-8740		DeCarlos McCullough		2145-30th Street, NE., D. C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) Multiple injuries		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
8147									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF					
		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 5:58P 9-27-87		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		pedestrian struck by an auto			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) hgw.		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Northbound Rt. 29 just N. of Howard Co., Md. Rt. 32 entrance					
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from		Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		M.D. Assistant		MEDICAL EXAMINER		DATE SIGNED		9-28-87	
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.		ADDRESS		111 Penn Street			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		10/04/87		Family Plot		Amherst, Va.			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Lawrence W. Plunkett, Inc. 3619-14th St., NW., Wash, D.C.		OCT 2 1987		Julia Bender-Lindner					

007070 OCT-2-01

066846 SEP 25 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26028

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) <b>DONALD S. FRANCIS</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>September 22, 1987</b>		2b. HOUR <b>8<sup>20</sup> A M</b>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 27 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>CONNECTICUT</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOWARD COUNTY GENERAL HOSP.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETAIL MANAGER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DRUG FAIR</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>ELLICOTT CITY</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>DONALD S. FRANCIS SR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER FANNING</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II</b>		17. INFORMANT ADDRESS <b>ELIZABETH FRANCIS 5333 KERGER ROAD 21043</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL ISCHEMIA, Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ATHEROSCLEROSIS</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 minute</b> <b>24 hrs.</b> <b>Years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>NO</b>							
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NONE</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 19_____, to _____, 19_____, that (we) last saw the deceased alive on <b>9-22</b> , 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I/we) did (did not) view the body after death.							
22b. SIGNATURE <b>William D. Parnes</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-22-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WILLIAM D. PARNES</b>				22e. ADDRESS <b>11085 LITTLE PATUXENT PKWY, COLUMBIA, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09/25/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LORRAINE PARK</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>WOODLAWN BALTIMORE MARYLAND</b>	
24. FUNERAL DIRECTOR NAME <b>ROY M &amp; RUSSELL C WITZKE FUNERAL HOMES</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 24 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	
1630 EDMONDSON AVE. CATONSVILLE MD. 21228							



065296 SEP 14 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26027  
2a. DATE OF DEATH MONTH DAY YEAR 9-5-87  
2b. HOUR 2 AM1. DECEASED NAME FIRST MIDDLE LAST  
(TYPE OR PRINT) MARGARET Delia FRANK3. SEX Female 4. RACE White 5. DATE OF BIRTH MONTH DAY YEAR 8 22 19  
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS. IF UNDER 1 YEAR IF UNDER 24 HRS.  
MONTHS DAYS HOURS MIN.7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ 9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.10. CITY OR TOWN OF DEATH Columbia 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard Co. General Hospital  
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Admin- Asst. 12b. KIND OF BUSINESS OR INDUSTRY Garment Wks.USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE Md. 13b. COUNTY Howard 13c. CITY OR TOWN Columbia 13d. INSIDE CITY LIMITS? YES ☐ NO ☒  
13e. STREET ADDRESS / ZIP CODE 6926 Allview Drive, Columbia 21046

14. FATHER'S NAME FIRST MIDDLE LAST George Frank 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Teresa McConville

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 218-09-1127 17. INFORMANT ADDRESS Dorothy Hartel Same as #13e

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a). heart failure  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). pulmonary hypertension  
DUE TO, OR AS A CONSEQUENCE OF (c).  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days  
yearsPART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. a  
Sjogren's syndrome, steroid diabetes, liver congest + coagulopathy19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒  
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from Sept 1, 19 87, to Sept 5, 19 87, that (I) (we) last saw the deceased alive on Sept 5, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE Patricia A. Tye MD DEGREE 22c. DATE SIGNED 9/5/87  
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia A. Tye MD 22e. ADDRESS 16772 Hickory Ridge Dr Columbia

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 9-8-87 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem Pk 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Md.

24. FUNERAL DIRECTOR NAME ADDRESS MacNabb Funeral Home Catonsville Md. 25a. DATE REC'D. BY REGISTRAR SEP 9 1987 25b. REGISTRAR'S SIGNATURE

062530 259 17 61



067647 OCT-5

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Maximilian Friedrich</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/30/87</b> 2b. HOUR <b>4 P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 5, 1904</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10799 Hickory Ridge Road 21044</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sporting Goods</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>Maryland</b>		13c. COUNTY <b>Howard</b>	13d. CITY OR TOWN <b>Columbia</b>	13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Johan Friedrich, .</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marie Amann</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>131 28 7819</b>		17. INFORMANT ADDRESS <b>Mrs Elizabeth Friedrich 10799 Hickory Ridge Rd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic atrial fibrillation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>several years</b> <b>"</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebrovascular insufficiency</b>					
19a. DATE OF OPERATION <b>9/29/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cerebrovascular insufficiency</b>		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)	
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21c. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9/30/87</b> to <b>9/30/87</b> , that (1) (we) first saw the deceased alive on <b>9/30/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.					
22b. SIGNATURE <b>Alan G. Stahl, M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9/30/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Alan G. Stahl, M.D.</b>		22e. ADDRESS <b>Columbia Medical Plan</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>Oct 1'87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk.</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 02 1987</b>			
24. FUNERAL DIRECTOR <b>HARRY H. WITZKE</b> <b>FUNERAL HOME INC</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tabular papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

9 4 2 1 0

064943 SEP-9 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this page to the funeral director. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, removal, or other disposition.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 26031					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clara M. Grable				2a. DATE OF DEATH MONTH DAY YEAR 9-3-87				2b. HOUR 11:50 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 14 21		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.			
10. CITY OR TOWN OF DEATH Howard Co.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hos.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 7246 Montgomery Rd., 21227	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Porter		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Bennett		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 214-22-2735		17. INFORMANT ADDRESS Anthony Grable, 5734 Elkridge Hts. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Metastatic breast cancer</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) <u>4 years</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) -					
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET -		CITY OR TOWN -		COUNTY -	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-24-87</u> to <u>9-4-87</u> that (I) (we) last saw the deceased alive on <u>9-3-87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE <u>Vincent Yang</u>				DEGREE M.D.				22c. DATE SIGNED 9-4-87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) VINCENT YANG				22e. ADDRESS Medical Staff Office, Howard General Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/8/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge		23d. LOCATION CITY OR TOWN Howard		COUNTY Md.	
24. FUNERAL DIRECTOR NAME Kaufman Funeral Home, 5695 Main St., Elkridge				25a. DATE REC'D BY REGISTRAR SEP 8 - 1987		25b. REGISTRAR'S SIGNATURE Julia Benson-Randall			

08403 SEP-281

RECEIVED

SEP 281

065545 SEP 15 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William M. Grevey			2a. DATE OF DEATH MONTH DAY YEAR 9/ 7/ 87		2b. HOUR 8 P M
3 SEX Male	4 RACE white	5. DATE OF BIRTH 10-16-1899 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 87	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Lorien Nursing Home		12a. USUAL OCCUPATION (TYPE AND MOST OF WORKING LIFE) Painter	12b. KIND OF BUSINESS OR INDUSTRY Industry	
13a. STATE Md.			13b. COUNTY P.G.	13c. CITY OR TOWN Beltsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Unknown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212-12-6823	17. INFORMANT Catherine Chilcoate ADDRESS 4715 Prince Georges Ave. same as above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-pulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebrovascular occlusive disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Parkinsons</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>N/A</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>83</u> , to <u>Present</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Donat A. Borwardt</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/8/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONAT A. CASAS		22e. ADDRESS 8317 CHERRY LA. LAUREL MD 20707			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-11-1987	23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION Baltimore Balt. County Md.
24. FUNERAL DIRECTOR NAME Donat A. Borwardt			ADDRESS 4400 Powder Mill Rd. Beltsville, Md. 20705		25a. DATE REC'D. BY REGISTRAR SEP 14 1987
					25b. REGISTRAR'S SIGNATURE Julia Davidson-Pandora

BP \_\_\_\_\_

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified prior to burial or cremation.

062242 SEP 12 67

062242 SEP 12 67

Handwritten text, possibly a name or address, appearing upside down.



X

Handwritten text, possibly a name or address, appearing upside down.

Handwritten text, possibly a name or address, appearing upside down.

Handwritten text, possibly a name or address, appearing upside down.

Handwritten text, possibly a name or address, appearing upside down.

Handwritten text, possibly a name or address, appearing upside down.

SEP 12 1967

066034 SEP 18 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST: Howard (nmn) MIDDLE: Hanks, Jr. LAST: Sept. 14 1987			2a. DATE OF DEATH MONTH: Sept. 14 1987 DAY: 14 YEAR: 1987 HOUR: M	
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH: 10 DAY: 25 YEAR: 1921	6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	IF UNDER 1 YEAR MONTHS: DAYS: HOURS: MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.	
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 10458 Fair Oaks Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Golden Rain Foundation	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE: Md. 13b. COUNTY: Howard 13c. CITY OR TOWN: Columbia			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13. STREET ADDRESS / ZIP CODE 10458 Fair Oaks Road 21044	
14. FATHER'S NAME FIRST: Howard MIDDLE: Hanks, Sr. LAST: Cecila		15. MOTHER'S MAIDEN NAME FIRST: Cecila MIDDLE: Leitner LAST: Leitner		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII WWII		16b. SOCIAL SECURITY NO. 071-12-9485		17. INFORMANT Caroline Hanks same as 13e
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mesothelioma Raul Cell Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs. 4 mos.</u>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (1) <u>this hospital</u> attended the deceased from <u>August 1</u> 19 <u>86</u> to <u>Sept. 14</u> 19 <u>87</u> that (1) <u>we</u> last saw the deceased alive on <u>August 11</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>we</u> did not <u>see</u> the body after death.				
22b. SIGNATURE <u>Ross C. Donenhouwer MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-14-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROSS C. DONENHOWER, M.D.		22e. ADDRESS Johns Hopkins Oncology Center		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 9/15/87	23c. NAME OF CEMETERY OR CREMATORY Balto. Wash. Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Laurel P.G. Md.	
24. FUNERAL DIRECTOR NAME: 7601 Sandy Spring Road Fleck Funeral Home, Inc. Laurel, Md. 20707		25a. DATE REC'D. BY REGISTRAR SEP 17 1987 25b. REGISTRAR'S SIGNATURE <u>John T. ...</u>		

MEDICAL CERTIFICATION

289

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



000000 000000

65232 SEP 10 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ellen B. Harper</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>9/8/87</i>		2b. HOUR <i>149 M</i>		
3. SEX <i>Female</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>07 10 94</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <i>93</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>England</i>		7b. CITIZEN OF WHAT COUNTRY? <i>England</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Howard County MD.</i>	
10. CITY OR TOWN OF DEATH. <i>Columbia</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Howard County General</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Stewarts</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Baltimore</i>		13c. CITY OR TOWN <i>Reisterstown</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <i>16 Austin Road 21136</i>		14. FATHER'S NAME FIRST MIDDLE LAST <i>Richard Radford</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Florence Emily Burnell</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>215-58-2800</i>		17. INFORMANT ADDRESS <i>Mr. Lewis Harper 11702 Falls Road Lutherville, MD. 21093</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>days</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <i>Gastrointestinal Bleeding</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <i>9/04/87</i> to <i>9/08/87</i> that (I) (we) lost saw the deceased alive on <i>9/07/87</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did not) view the body after death.							
22b. SIGNATURE <i>B.H. Minchew</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>B.H. Minchew</i>		22e. ADDRESS <i>2850 N. Ridge Rd. Ellicott City Md 21043</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>9/11/87</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parkwood Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Parkville Baltimore MD.</i>	
24. FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, Inc.</i>				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>	
ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>				SEP 09 1987			

MEDICAL CERTIFICATION

9/9

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove suspension papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other multiple cause, the medical examiner must be notified at once.

SEP 10 1961

SEP 10 1961

3  
064800 SEP 4 87

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH													
1. FOR STATE REGISTRAR		2. REG. NO. 26635				3. DATE OF DEATH MONTH DAY YEAR 9-01-87				4. HOUR 12:18 AM			
5. DECEASED NAME (TYPE OR PRINT) MAUDE ESTER HARRIS		6. SEX Female		7. RACE Negro		8. DATE OF BIRTH MONTH DAY YEAR 6-12-90		9. AGE (IN YEARS LAST BIRTHDAY) 97 YRS		10. IF UNDER 1 YEAR MONTHS DAYS		11. IF UNDER 24 HRS. HOURS MIN.	
12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS		13. CITIZEN OF WHAT COUNTRY? USA		14. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		15. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.							
16. CITY OR TOWN OF DEATH Columbia		17. NAME OF HOSPITAL (NURSING HOME OR OTHER INSTITUTION) (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIE NURSING HOME 6334 Cedar Lane Columbia Md. 21044				18. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		19. KIND OF BUSINESS OR INDUSTRY Domestic					
20. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				21. STATE Maryland		22. COUNTY Howard		23. CITY OR TOWN Columbia		24. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		25. STREET ADDRESS / ZIP CODE 6220 Foreland Garth 21045	
26. FATHER'S NAME FIRST MIDDLE LAST Zack		27. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Handy		28. 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				29. 16b. SOCIAL SECURITY NO. 453-20-8961		30. 17. INFORMANT Hansome Walton 6220 Foreland Garth Apt. B Columbia, Md., 21045			
31. 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary artery disease												32. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 min	
33. DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis												34. 9/2/87	
35. DUE TO, OR AS A CONSEQUENCE OF (c)													
36. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a													
37. 19a. DATE OF OPERATION				38. 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				39. 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		40. 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
41. 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				42. 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				43. 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
44. 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				45. 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				46. 21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
47. 22a. I certify that (I) (this hospital) attended the deceased from 1979, 19, to September 1, 1987, that (I) (we) last saw the deceased alive on 8/31/87, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
48. 22b. SIGNATURE Charles Taylor M.D.								49. DEGREE		50. 22c. DATE SIGNED			
51. 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLE TAYLOR M.D.								52. 22e. ADDRESS Knoll North Drive Col. Md 21045					
53. 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				54. 23b. DATE 9/4/87		55. 23c. NAME OF CEMETERY OR CREMATORY Crestlawn				56. 23d. LOCATION CITY OR TOWN COUNTY STATE Marriottsville Howard Md.			
57. 24. FUNERAL DIRECTOR HARRY H. WITZKE				58. 4112 Columbia Rd. Ellicott City, Md., 21043				59. 25a. DATE REC'D. BY REGISTRAR SEP 3 1987		60. 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

004800 SEP-4 67

Domestic

6520 Forwarded Date 21065

Colombia

Forward

Forward

Hand

Elizabet

Tollman

Back

6520 Forwarded Date 21065

Colombia; No. 21065

Handwritten text

No



Charlotteville Forward

Crossman

WAVA

Serial

412 Columbia St.  
Elizabet New, N.J. 07201

HANNA S. WILSON

067648 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician on and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove captioned papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GODFREY A. HERDER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 29 87</b>			2b. HOUR <b>8:55A</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAU.</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>08 22 93</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LORIED NSG. HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Bank Administrator</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>HOWARD</b>		13c. CITY OR TOWN <b>COLUMBIA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>6334 CEDAR LANE 21044</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Albert Herder</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (1) NO OR UNKNOWN (2) YES, GIVE WAR OR DATES <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-09-3621</b>		17. INFORMANT ADDRESS <b>Godfrey J Herder 3345 N. Chatham Rd 21043</b>					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Aortic Stenosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atherosclerosis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b> <b>Years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> 19 <b>88</b> to <b>Sept 29</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/4</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Seary J. Lewis MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>9-29-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Columbia, Md 21044</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>SEpt 30'87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview Memorial Pk.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto., Md.</b>			
24. FUNERAL DIRECTOR <b>Harry H Witzke 4112 Old Columbia Pike Ellicott City</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 02 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Judith Davidson-Randall</b>			

BP

085889 OCT-201

20A COTTON FIBER

OCT 05 1981



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requirement that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return this copy to the Registrar. Pages 1 and 2 should be filed with the Registrar. Removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition is prohibited. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				26037			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Richard Carroll Hewitt, Sr.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>9 2 87</b>			
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 3 94</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Paul Hewitt</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Claudia Carroll</b>		16. STREET ADDRESS / ZIP CODE <b>445 W. Old Liberty Rd. 21784</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW 1 218-14-9493A</b>		17. INFORMANT <b>Claudia M. Goss, 26 Maple Ave. Walkersville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CVA</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 min.</b> <b>2 days</b> <b>3 days</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Senile Dementia, hypertension, osteoarthritis, ASCVD</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) (this hospital) attended the deceased from <b>8/31</b> 19 <b>82</b> , to <b>9/2</b> 19 <b>82</b> , that (b) (we) lost above, (b) (we) did not view the body after death.							
22b. SIGNATURE <b>Charles E. Sheehan III MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/2/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles E. Sheehan III MD</b>		22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>9-3-1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Security Process</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Charles W. Burrier, Jr., Sykesville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 08 1987</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Gordon-Randall</b>			

BP

062539 SEP 14 87

104

RECEIVED  
SEP 14 1987

1

ADP

CHURCH OF THE LIVING GOD

CHURCH OF THE LIVING GOD

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
Anthony Hood			9-17 1987			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
Male	White	06 - 08 - 60	27 YRS.			9-17 1987	4:30P	M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Delaware		U.S.A.		WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Howard County MD		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Ellicott City		McKenzie Road and Guide Road				Construction Worker		Construction
13. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		
Maryland		Baltimore		Timonium		40 Greenmeadow Drive 21093		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
David A. Hood			Helen L. Mumford					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.			17. INFORMANT		
NO			222-44-4668			Deborah L. Hood Timonium, MD 21093		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Head Injuries								
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
			2:00PM 9-17-87		Subject buried under soil			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			clearing project		McKenzie Road and Guide Road Howard Co Maryland			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Mario F. Golle, Jr., M.D.			Assistant			9-18-87		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Mario F. Golle, Jr., M.D.			111 Penn Street, Balto, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL			09-19-87		Springfield Cemetery		Sykesville Carroll MD	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
HAIGHT FUNERAL HOME			SEP 22 1987			Julia Decker-Rodgers		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORMS 1-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 (PRIOR TO BURIAL, CREMATION, OR REMOVAL).

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

186400 SEP 23 81

186400 SEP 23 81

065648 SEP 15 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

25039

1. DECEASED NAME (TYPE OR PRINT) Catherine M. Hooper			2a. DATE OF DEATH MONTH DAY YEAR Sept. 5, 1987		2b. HOUR 10:30 A M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 28 1900		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Howard MD.		
10. CITY OR TOWN OF DEATH Ellicott City	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4901 Roundhill Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland			13b. COUNTY Howard	13c. CITY OR TOWN Ellicott City	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John McCarthy			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 214-82-8408		17 INFORMANT ADDRESS Catherine M. Hooper 4901 Roundhill Rd. Ellicott City, Md 21043	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>vertebrobasilar insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs. yrs.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Recent loss suspected of malignancy; Alzheimer's disease</u>					
19a. DATE OF OPERATION -	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>-years-</u> 19 <u>87</u> to <u>5 Sept</u> 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>1 Sept</u> 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>KOLODRUBETZ MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KOLODRUBETZ Primary CARE SPECIALISTS		22e. ADDRESS Suite 103 2850 N Ridge Rd Ellicott City MD 21043			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/8/87	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR HARRY H. WITZKE 4112 Columbia Road Ellicott City, Md. 21043		25a. DATE REC'D. BY REGISTRAR SEP 14 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please stamp on page 3. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked at item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)



067570 OCT

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Amelia J. Hawk</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/29/87</b>		2b. HOUR M <b>AM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>6/22/92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD	
10. CITY OR TOWN OF DEATH <b>Ellicott City</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Bon Secour Extended Care</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Baltimore</b>	13c. CITY OR TOWN <b>Rockdale</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>3637 Coronado Road 21207</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edward Fahey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Cornell</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>220-46-4447</b>		17. INFORMANT ADDRESS <b>Mr. Allen H. Lyon 3637 Coronado Road Baltimore Maryland 21207</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Aspiration pneumonia</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/87</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>dysphagia</b>					<b>7/87</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Right middle Cerebral artery stroke</b>					<b>7/87</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Congestive heart failure, SEMI, Atrial fibrillation</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>9/29</b> 19 <b>87</b> to <b>9/29</b> 19 <b>87</b> , that (1) we last saw the deceased alive on <b>9/29</b> 19 <b>87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (1) we (did) view the body after death.					
22b. SIGNATURE <b>Rhodumbet MD</b>				22c. DATE SIGNED <b>9/30/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KOLODRNBTZ</b>				22e. ADDRESS <b>Suite 103 2850 N Ridge Rd Ellicott City MD 21043</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/01/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park Mausoleum</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Baltimore MD</b>		23e. DATE REC'D. BY REGISTRAR <b>OCT 2 1987</b>			
24. FUNERAL DIRECTOR NAME <b>Loring Byers Funeral Directors, Inc</b> <b>8728 Liberty Road Randallstown Maryland 21133</b>				25. REGISTRAR'S SIGNATURE <b>Julia Benson-Randall</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

BP



10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

10/10

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (Type or Print) Cecil Atwood HUGHES			2a. DATE OF DEATH MONTH DAY YEAR Sep. 18, 1987		2b. HOUR 9:00 A.M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Sep. 3, 1910	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	9. CITIZEN OF WHAT COUNTRY? U.S.A.	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.		
12. CITY OR TOWN OF DEATH Columbia	13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hospital		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter	15. KIND OF BUSINESS OR INDUSTRY Shipbuilding	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE Virginia	17b. COUNTY Northumberland	17c. CITY OR TOWN Burgess	17d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	17e. STREET ADDRESS / ZIP CODE P.O. Box 102 22432	
18. FATHER'S NAME FIRST MIDDLE LAST Robert James Hughes		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie M. Mitchel			
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		21. SOCIAL SECURITY NO. 241-16-2202		22. INFORMANT ADDRESS Ellicott City 21043 Frederick Road	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours
---	--	---

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Atrial fibrillation; hyperkalemia; renal failure</u>			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/18</u> , 19 <u>87</u> , to <u>9/18</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>9/18</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.			
22b. SIGNATURE <u>B. J. Minchew, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9/18/87</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Harvey B. Minchew</u>		22e. ADDRESS Baltimore National Pike	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 09-22-87	23c. NAME OF CEMETERY OR CREMATORY Roseland Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Reedville, Northumberland, VA
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.		25. DATE REC'D. BY REGISTRAR SEP 21 1987	



065826 SEP 16 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26642

1. DECEASED NAME (SURNAMES) WALTER KENNETH JOHNSON, Sr.			2a. DATE OF DEATH MONTH DAY YEAR September 10 1987		2b. HOUR 4:00A <sub>M</sub>
3 SEX MALE	4 RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR June 22 1905		6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) LAURENCE, MASS.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HOWARD Co. MD.		
10 CITY OR TOWN OF DEATH JESSUP	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7926 Old Jessup Road		12a. USUAL OCCUPATION (OCC.) (TYPE OF WORK FOR MOST OF WORKING LIFE) Civil Engineer	12b. KIND OF BUSINESS OR INDUSTRY Civil Service	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY HOWARD	13c. CITY OR TOWN JESSUP	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7926 Old Jessup Road 20794
14 FATHER'S NAME FIRST MIDDLE LAST Samuel L. Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Hunter			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-46	17. INFORMANT (Wife) ADDRESS PEGGY JOHNSON SAME AS #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 days.
DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension		
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Heart Disease		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
------------------------	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
--	--	--

21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE
---	--	---

22a. I certify that (I) (this hospital) attended the deceased from 2-18-1986, 19\_\_\_\_, to 9-5-1987, 19\_\_\_\_, that (I) (we) lost saw the deceased alive on 9-5-1987, 19\_\_\_\_, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

22b. SIGNATURE N. B. Vellanki	DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-10-1987.
----------------------------------	--	--------------------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. B. VELLANKI	22e. ADDRESS 9055, Chevrolet Drive, #Suite 101, Ellicott City, Maryland 21043.
---	---

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept 12, 1987	23c. NAME OF CEMETERY OR CREMATORY Meadowridge mem. Park	23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland
---	----------------------------	---	--

24 FUNERAL DIRECTOR NAME ADDRESS Singleton Funeral Home Glen Burnie, Maryland	25a. DATE REC'D. BY REGISTRAR SEP 15 1987	25b. REGISTRAR'S SIGNATURE Julia D. [Signature]
---	--	--

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card numbers 1 and 2 and file with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

002850 SEP 12 85

066916 SEP 28 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

26043

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ANN S. KLEIN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9-22-87</b>		2b. HOUR <b>5 15 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>04 04 90</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>N.Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County MD.</b>
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Horien N.H.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Shapero</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Miriam Marwell</b>		13e. STREET ADDRESS / ZIP CODE <b>4730 Sheppard Lane 21043</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>017-07-6933d</b>		17. INFORMANT ADDRESS <b>Donald C. Klein 4730 Sheppard Lane Ellicott City, Maryland 21043</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac arrest</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5</b> <b>15</b> <b>20</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NO! WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (his hospital) attended the deceased from <b>Sept 19 87</b> to <b>Sept 19 87</b> , that (I) (we) lost saw the deceased alive on <b>Sept 19 87</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <b>Warren M. Ross M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/22/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Warren M. Ross, M.D.</b>				22e. ADDRESS <b>11065 Little Patuxent Pkwy. Columbia MD 21044</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9-25-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'nai Brith Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Worcester, Mass.</b>
24. FUNERAL DIRECTOR <b>Gary S. Kaufman Funeral Home 5695 Main St. Elkridge, Maryland 21227</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 25 1987</b>		
				25b. REGISTRAR'S SIGNATURE <b>Lia Rosen-Randee</b>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

000018 SEP 30 01

COTTON FIBER



067262 OCT 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wallace S. MABEN			2a. DATE OF DEATH MONTH DAY YEAR 9 26 87			2b. HOUR 4:16a M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Apr. 4 09		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD.			
10. CITY OR TOWN OF DEATH Columbia		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lorien Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Foreman		12b. KIND OF BUSINESS OR INDUSTRY Water Dept.	
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1114 Pine Heights Avenue 21229	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Staisloff						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---		17. INFORMANT Helen M. Maben, 1114 Pine Heights Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>impaired respiratory gag</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebrovascular accident/dysphagia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 months</u> <u>2 mo</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Organic brain syndrome, hyperglycemia</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>8/5</u> 19 <u>87</u> , to <u>25 Sept</u> 19 <u>87</u> , that (1) (we) lost saw the deceased alive on <u>9/25/87</u> 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) not view the body after death.									
22b. SIGNATURE <u>Robert Kolodrubetz</u>				DEGREE 8		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9/28/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Kolodrubetz				22e. ADDRESS Ellicott City 2850 North Ridge Rd. Suite 103					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/29/87		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.				ADDRESS 21229		25a. DATE REC'D. BY REGISTRAR SEP 29 1987		25b. REGISTRAR'S SIGNATURE <u>Julia ...</u>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

007505 001-181

SEP 28 1961

066397 SEP 22 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 and file them with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 28 shows any injury, or other traumatic event, the medical examiner must be notified of this.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Lillian Miriam Mauck</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 15 87</b>		2b. HOUR <b>2025</b> M
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>08 22 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72.</b> YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Balto. Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard.</b> MD	
10. CITY OR TOWN OF DEATH <b>Columbia</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Gen Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>CLARKSVILLE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>11271 Old Hopkins Road. 21029</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lemuel W. Peters</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lillian Moore</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>218-30-5988</b>		17. INFORMANT <b>Bernard L. Mauck</b> ADDRESS <b>same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, acute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9-15</b> , 19 <b>87</b> , to <b>9-15-87</b> , 19 <b>87</b> , that (I) (we) lost saw the deceased alive on <b>9-15</b> , 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Richard W. Smith M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>9-15-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Richard W. Smith, M.D.</b>		22e. ADDRESS <b>10802 Hickory Ridge Rd. Columbia, Md. 21049</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/19/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>	
23d. LOCATION <b>Fulton</b>		23e. COUNTY <b>Howard</b>		23f. STATE <b>Md.</b>	
24. FUNERAL DIRECTOR NAME <b>7601 Sandy Spring Rd. Fleck Funeral Home, Inc. Laurel, Md. 20707</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 21 1987</b>	
25b. REGISTRAR'S SIGNATURE <b>John Davidson-Hendall</b>					

068307 SEP 25 81

068307 SEP 25 81

Black Forest, Inc. Laurel, Md. 20723

7501 Sand Spring Rd.  
Laurel, Md. 20723

Black Forest, Inc.  
Laurel, Md. 20723

Black Forest, Inc.  
Laurel, Md. 20723

Black Forest, Inc.  
Laurel, Md. 20723

Black Forest, Inc.  
Laurel, Md. 20723

Black Forest, Inc.  
Laurel, Md. 20723

066253 SEP

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2, which should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 4 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VIA 15, 4)item 16b corr per  
FOR tele call fun.dir.  
STATE REGISTRAR 4/6/89 jdSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

260  
26646

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eileen A McGirr</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>9/3/87</b>		2b. HOUR <b>7:08 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 30 95</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attendant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES McDONALD</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>HELEN COCKS</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>816-33-468</b>		17. INFORMANT <b>PAGE MCGIRR</b>		ADDRESS <b>507 BUTTERCROFT ELLICOTT CITY, MD 21043</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiac arrest post pulmonary</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>embolism</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>fracture, left femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Fracture, left femur</b>							
19a. DATE OF OPERATION <b>9-3-87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Fracture, left femur</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9-2 1987</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Fell while walking in nursing home</b>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Extended Care Facility</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3000 N. Ridge Rd. Ellicott City MD 21043</b>			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John C. Payne, MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>SEP 18 1987</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John C. Payne</b>				22e. ADDRESS <b>How. County Gen.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5 SEPT 87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CROSTOWN MEM. GDN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>MARRIOTTSVILLE HOWARD MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>SLACK FUNERAL HOME ELLICOTT CITY MD 21043</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia D. Smith</b>	

000523 SEP 18 01

32X COTTON FALBICK

12/11/01



65762 SEP 16 87

FOR  
STATE  
REGISTRAR

Linda Catherine Mosher

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26047

1. DECEASED NAME (TYPE OR PRINT) <b>LINDA Catherine MOSHER</b>			2a. DATE OF DEATH MONTH <b>12</b> DAY <b>87</b> YEAR <b>45</b> HOUR <b>45</b> AM	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>15</b> YEAR <b>48</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>38</b> YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD Co. MD.</b>
10. CITY OR TOWN OF DEATH <b>COLUMBIA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard Co. Gen. Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Writer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Self - Emp.</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>	13c. CITY OR TOWN <b>Columbia</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST <b>John</b> MIDDLE <b>M.</b> LAST <b>Bush</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Mary</b> MIDDLE <b>L.</b> LAST <b>Dawson</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>227-70-9296</b>		17. INFORMANT ADDRESS <b>Columbia 21045</b> <b>William R. Mosher - 9528 Kilimanjaro Rd.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent + Metastatic Hodgkin's lymphoma</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1963 + 1981</b>
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Intractable Pain from Sacral Metastases.</b>				<b>3 months.</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>disseminated intra vascular coagulation</b>				<b>2d.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Gnathosis + ascites, w/o sepsis, adult resp distr syndrome,</b>				
19a. DATE OF OPERATION <b>8/28/87</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Venous Access - no complications</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>9/12</b>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>8/13</b>		21f. LOCATION STREET <b>9/12</b> CITY OR TOWN <b>87</b> COUNTY <b>87</b> STATE
22a. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> 19 <b>87</b> to <b>9/12</b> 19 <b>87</b> , that (I) (we) last saw the deceased alive on <b>9/12</b> 19 <b>87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Patrice A. Toye, MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/12/87</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICE A. TOYE, MD</b>		22e. ADDRESS <b>10772 Hickory Ridge Road, Columbia</b>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>	23b. DATE <b>09-15-1987</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Westview Crematory</b>	23d. LOCATION CITY OR TOWN <b>Catonsville</b> COUNTY <b>Baltimore</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Lero M. &amp; Russell C. Witzke</b> ADDRESS <b>Funeral Homes P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>SEP 15 1987</b> 25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		
5555 Twin Knolls Rd., Columbia, MD. 21045				

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certificate must be notified of any.

BP



62703 2092 20723

065902 SEP 17 1987

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26648

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NABEL J. MINER			2a. DATE OF DEATH MONTH DAY YEAR 09 15 87			2b. HOUR 2:05 P.M.				
3 SEX FEMALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 09 01 11		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.				
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIED NSG. HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD.					13b. COUNTY HOWARD		13c. CITY OR TOWN COLUMBIA		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FREDRICK JOSEPH JAMES					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET BROWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 204-09-8048		17. INFORMANT ADDRESS RONALD MINER - HUSBAND - s/a						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>atrial fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary arterio sclerotic heart disease</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9/6/87</u> <u>6/87</u> <u>YEARS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>tracheostomy with endotracheal tube, anemia</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 19 <u>87</u> , to <u>9/15</u> , 19 <u>87</u> , that (2) (we) last saw the deceased alive on <u>9/15</u> , 19 <u>87</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)										
22b. SIGNATURE <u>R. Kolodrubetz MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>9/15/87</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KOLODRUBETZ</u>				22e. ADDRESS <u>Suite 103</u> <u>2850 N. Ridge Rd</u> <u>Ellicott City, MD</u> <u>21043</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9-15-87		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME State Anatomy Board				ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR SEP 16 1987		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be immediately filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon copies of this certificate and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 showing injury, or other traumatic event, the State Department of Health and Mental Hygiene must be notified at once.

002205 209 17 01

0022005 SEP 17 63

10

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (LAST, FIRST, MIDDLE, LAST)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Conrad Muhl, Jr.		9/27/87		2:45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR MONTHS DAYS	
Male	Caucasian	3/11/26	61 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MD.		
Maryland	U.S.A.		Howard County		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Columbia	Howard Co. General Hosp.		Proof Reader		News American

13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE		21133
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	9829 Branchleigh Road		
Maryland	Baltimore	Randallstown					

14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME		
FIRST	MIDDLE	LAST	FIRST	MIDDLE	LAST
Conrad A.	Muhl		Bertha	Thalwitzer	

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No	220-14-7716	Mrs. Carol Hickman	9829 Branchleigh Road Randallstown Maryland 21133

<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>VENTRICULAR FIBRILLATION</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY ARTERY DISEASE</u>	<u>Years</u>
	DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROSIS</u>	


PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Depression; Congestive Heart Failure; Prosthetic aortic valve

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>

11a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR    A.M.    MONTH    DAY    YEAR P.M.                        19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)
---	---	---

214 INJURY OCCURRED	21e PLACE OF INJURY [AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					

22a. I certify that (I) (this hospital) attended the deceased from 9/19, 1987, to 9/27, 1987, that (I) (we) lost  
saw the deceased alive on 9/27, 1987, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE 	DEGREE M.D.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/27/87
---	----------------	---	---	--	-----------------------------

22d PHYSICIAN'S NAME (TYPE OR PRINT)	22e ADDRESS
--------------------------------------	-------------

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 9/30/87	23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park	23d. LOCATION CITY OR TOWN Sykesville Carroll	COUNTY STATE MD
--	----------------------	---	---	-----------------------

24. FUNERAL DIRECTOR NAME 8728 Liberty Road Randallstown Maryland 21133	Loring Byers Funeral Directors, Inc ADDRESS	25a. DATE REC'D. BY REGISTRAR SEP 28 1987	25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall
---	--	--	--

**MEDICAL CERTIFICATION**

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove the certificate to the Department of Health and Mental Hygiene, or remove it with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked "Other," there is another traumatic event, other than a traumatic event. The medical examiner will be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

084337 2630 61

068042 OCT

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSMITTAL. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		DECEASED NAME FIRST MIDDLE LAST Elmer Eugene MULLINS		2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9-22 1987		2b. HOUR M	
3 SEX Male	4 RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 5-5-32	6 AGE (IN YEARS) (LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9-22 1987	2d. HOUR M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Howard COUNTY MD.	
10. CITY OR TOWN OF DEATH Elkridge		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6479 Anderson Avenue			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security		12b. KIND OF BUSINESS OR INDUSTRY U S Govt
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Roy Mullins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josie Orton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 212 28 1019		17 INFORMANT ADDRESS Vaughnell Mullins same as above			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Thomas F. Herbert		TITLE (SPECIFY) Deputy		DATE SIGNED 9-22-87			
EXAMINER'S NAME (TYPE OR PRINT) Thomas F. Herbert MD.		ADDRESS Ellicott City MD 21043					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept 25, 1987		23c. NAME OF CEMETERY OR CREMATORY Liberty Baptist Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Lisbon, Md	
24 FUNERAL DIRECTOR NAME Donaldson Funeral Home Laurel, Maryland		ADDRESS		25a. CERTIFIED BY REGISTRAR SEP 30 1987			

068042 OCT-08

First Eugene  
Walt Lake 2-22-07  
Hanson County

Curran, John  
Walt Lake  
Hanson County

James J. Whit  
James F. Whit  
Walt Lake  
Hanson County

WALT LAKE

REGISTERED



REG. NO.

18 03 932 01 5720

065579 SEP 15 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it must be filed by the funeral director, page 3 should be detached for use as the burial-transit permit. When possible, remove coroners papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medicolegal examiner must be notified at once.

BP

DHMH - 16 60M 7/84 (VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (Last, first, middle, or initials) <b>Russell Upfold Pierce</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Sept. 6, 1987</b>			2b. HOUR MIN. <b>8:00 A</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 27 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Irwin, Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>Laurel</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10973 Scaggsville Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Navy Yard</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>10973 Scaggsville Rd. 20707</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas M. Pierce</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth O'Cargo</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1917-1919</b>		16c. SOCIAL SECURITY NO. <b>187-01-8654</b>		17. INFORMANT ADDRESS <b>Evelyn Lonas same as 13e</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Obstructive Pulmonary Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>9/4/87</b> to <b>9/6/87</b> , that (I) (we) last saw the deceased alive on <b>9/4/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not see the body after death, so state.)									
22b. SIGNATURE <b>Dr. Holmes</b>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>9/6/87</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Holmes</b>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>9/10/87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery Brentwood P.G. Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, Md. 20707</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 14 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

0 9 2 3 7 9 3 6 1 2 8 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068256 OCT 13 87

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Leland F. Ramsdell</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>Sept 29, 1987</b>		2b. HOUR <b>7PM M</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>November 29, 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wyoming</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>HOWARD COUNTY MD</b>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7128 Lasting Light Way 21045</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired U.S. Government</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Columbia</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harrison Ramsdell</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma</b>		13e. STREET ADDRESS / ZIP CODE <b>7128 Lasting Light Way 21045</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. <b>390 07 4551 A</b>		17. INFORMANT ADDRESS <b>Mrs Marjorie Ramsdell 7128 Lasting Light Way</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cleer cell carcinoma of kidneys with metastasis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic heart failure</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>September 29, 1987</b> to <b>September 29, 1987</b> , that (I) (we) last saw the deceased alive on <b>September 29, 1987</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Charles E. Taylor MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9-30-87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles E. Taylor MD</b>				22e. ADDRESS <b>2 Knoll Wood Drive Columbia MD 21045</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>October 1'87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westview</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Catonsville Balto., Maryland</b>	
24. FUNERAL DIRECTOR'S NAME <b>HARRY H. WITZKE</b>		4112 OLD COLUMBIA PIKE <b>ELLICOTT CITY MD 21043</b>		25a. DATE REC'D BY REGISTRAR <b>OCT 02 1987</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julia Darden-Ruback</b>			

060520 1317

065144 SEP 10 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE XXX RAUCH			2a. DATE OF DEATH MONTH DAY YEAR 9 1 87			2b. HOUR MIN 6:28 PM	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 04 05 98		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) AUSTRIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard COUNTY MD			
10. CITY OR TOWN OF DEATH Columbia	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOWARD CO. GENERAL HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.			13b. COUNTY Howard	13c. CITY OR TOWN Columbia	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 7080 CRADLEROCK WAY 21045	
14. FATHER'S NAME FIRST MIDDLE LAST LEON KARNIOL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 098-10-0894		17. INFORMANT ADDRESS MD 21093 LEONARD RAUCH 11511 WOODLAND DR. LUTHERVILLE			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac arrhythmia</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive heart disease</u>		<u>years</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19 <u>75</u> , to <u>Sept 1</u> , 19 <u>87</u> , that (I) (we) last saw the deceased alive on <u>August 28</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Charles E Taylor</u> M.D.		DEGREE M.D.	22c. DATE SIGNED 9-1-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles E Taylor</u> M.D.		22e. ADDRESS <u>2 Knoll North Drive, Columbia Md 21045</u>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9/4/87	23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEMORIAL	23d. LOCATION CITY OR TOWN COUNTY STATE PARK REISTERSTOWN BALTO MD
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO. MD 21215		25a. DATE REC'D BY REGISTRAR SEPO 9 1987	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 7 and 8 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at item 18, please any injury, or other traumatic event, the medical examiner must be notified of this.



06214 SEP 10 87

20% COTTON FIBER  
100% COTTON FIBER

X

SEP 09 87

067263 OCT 1 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Christopher L. REICH					2a. DATE OF DEATH MONTH DAY YEAR 9 26 87			2b. HOUR 10:15P M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 25 13		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard County MD					
10. CITY OR TOWN OF DEATH Elkridge		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6133 Hunt Club Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY ContainerMfg.			
13a. STATE Maryland		13b. COUNTY Howard		13c. CITY OR TOWN Elkridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6133 Hunt Club Road, 21227			
14. FATHER'S NAME FIRST MIDDLE LAST Christian Reich				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie May Maddox							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-05-1223		17. INFORMANT ADDRESS Lillian M. Reich, 6133 Hunt Club Road							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Empyema of left chest</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) <del>was</del> lost saw the deceased alive on <u>Sept 23 19 87</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (If <del>myself</del> did not view the body after death)											
22b. SIGNATURE <u>Gregory F. McAuliffe, MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9.28.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Adams Gregory F. McAuliffe, MD				22e. ADDRESS 720 Maiden Choice Lane							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/30/87		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard Maryland					
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc., 4107 Wilkens Ave.				25a. DATE REC'D. BY REGISTRAR 21229 SEP 29 1987		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

087583 OCT 1 81

172

1000

1000

1000

1000

1000

1000

1000

087583

066135 SEP 8 87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 100.3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										26650 REG. NO.					
1- STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) <b>ROSE DELL ROBERTS</b>										7a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> <b>09 12 1987</b>		7b. HOUR <b>4:00 PM</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MAY 28 1916 71</b> YRS.		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN.		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD <b>09 12 1987</b>		7d. HOUR <b>4:00 PM</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NORTH CAROLINA</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard</b> MD.			
10. CITY OR TOWN OF DEATH <b>JESSUP</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8110 Washington Blvd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MD</b>				13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>JESSUP</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8110 WASHINGTON BLVD</b>				20794	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elisha C. Thigpen</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Willie Evans</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>578 24 9605</b>		17. INFORMANT ADDRESS <b>Milton Roberts-son- Rt. 1 Box 352</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF LUNG</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>										Colonial Beach, Virginia					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>Bert F. Morton</b>				M.D. <b>Howard</b>				DATE SIGNED <b>9/12/87</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>BERT F. MORTON</b>				ADDRESS <b>2802 Montclair Dr Ellicott City</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>Sept. 19, 1987</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial Cemetery, Suitland, Md</b>				23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME <b>John I. Stewart, III</b>				ADDRESS <b>Stewart Funeral Home-4001 Benning Road,</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 17 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

000132 SEP 1981

REBIT NOTIC



066506 SEP 23 1987

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ESTHER L. SINGLEY			2a. DATE OF DEATH MONTH DAY YEAR 09 19 87		2b. HOUR 8 <sup>05</sup> P M		
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 08 93		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Howard COUNTY MD	
10. CITY OR TOWN OF DEATH COLUMBIA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Howard County General Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME	
13a. STATE NEW JERSEY		13b. COUNTY CAPE MAY		13c. CITY OR TOWN WILDWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE 123 E. 21ST. STREET 08260		14. FATHER'S NAME FIRST MIDDLE LAST JOHN WILSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA HERRMANN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	
16b. SOCIAL SECURITY NO. 182-05-5766		17. INFORMANT THELMA E. CAVICCHIO		18. ADDRESS 206 ROLLING DALE ROAD CATONSVILLE, MD. 21228			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Aspiration pneumonia

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Dysphagia

DUE TO, OR AS A CONSEQUENCE OF

(c) Cerebrovascular accidentBETW.  
weeks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>8/17</u> , 19 <u>87</u> , to <u>9/19</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>9/19</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>B.H. Minchew, M.D.</u>				DEGREE M.D.		22c. DATE SIGNED 9/19/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.H. Minchew				22e. ADDRESS 2850 N. Ridge Rd. Ellicott City, Md 21043			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 9/23/87		23c. NAME OF CEMETERY OR CREMATORY PRESBYTERIAN CHURCH		23d. LOCATION CITY OR TOWN COUNTY STATE COLD SPRING NEW JERSEY	
24. FUNERAL DIRECTOR MRS. M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228				25a. DATE REC'D. BY REGISTRAR SEP 22 1987			
				25b. REGISTRAR'S SIGNATURE <u>John L. ...</u>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

068709 295381

SEP 28 1952



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

067510 OCT

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

25658

1. STATE REGISTRAR		2. REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST		MONTH DAY YEAR	
GERTRUDE J. SMITH		09 28 87	
3. SEX		4. RACE	
FEMALE		WHITE	
5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MONTH DAY YEAR		YRS MONTHS DAYS	
10 22 27		59	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	
MARYLAND		U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	
ELKRIDGE		7003 MAGNOLIA AVENUE	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
STORE OWNER		SELF-EMPLOYED	
13a. STATE		13b. COUNTY	
MARYLAND		HOWARD	
13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
ELKRIDGE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME	
FIRST MIDDLE LAST		FIRST MIDDLE LAST	
CLARENCE P. REIMSNIDER		GERTRUDE POWELL	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
NO		214-24-5746	
17. INFORMANT		ADDRESS	
RICHARD E. SMITH		7003 MAGNOLIA AVE. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Liver failure		2 mo	
DUE TO, OR AS A CONSEQUENCE OF		yes	
(b) Cirrhosis of liver		yes	
DUE TO, OR AS A CONSEQUENCE OF		yes	
(c) Chronic ethanol abuse			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (Renal failure)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) the deceased died on (date) 19 87 to 19 87 that (I) lost saw the deceased die on above (I) did not see the body after death			
22b. SIGNATURE			
DEGREE			
22c. DATE SIGNED			
9.29.87			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
GREGORY MCAULIFFE, M.D.			
22e. ADDRESS			
720 MAIDEN CHOICE LANE, 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
BURIAL		10-01-87	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
ZION CEMETERY		ELKRIDGE HOWARD MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
NAME		1987	
GARY L. KAUFMAN FUNERAL HOME ELKRIDGE, MD.		25b. REGISTRAR'S SIGNATURE	
		John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



8-87

FOR  
**87**  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Russell J. Smith</b>		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 9/ 8/ 19 87		2b. HOUR 3:00 P M	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 5, 1917</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>70 YRS.</b>	7. IF UNDER 1 YR. MONTHS DAYS <b>70</b>	7. IF UNDER 24 HRS. HOURS MIN. <b>70</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Illinois</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Columbia</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Howard County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Self Emp. Contract. Roofing/36</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Ellicott City</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Andrew Smith</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Zona Lem</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>	
17. INFORMANT <b>R. Thomas Smith</b>		18. SOCIAL SECURITY NO. <b>212-05-6894</b>		19. ADDRESS <b>14120 Rover Mill Rd West Friendship, MD 21794</b>	
1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ <b>Shotgun Wound of Abdomen</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? ABDOMEN ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <del>XXX</del> MONTH DAY YEAR P.M. <b>9/ 8/ 19 87</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>self inflicted wound</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3141 Pine Orchard Lane, Ellicott City, Md.</b>	
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Mario F. Golle, Jr.</b>		TITLE (SPECIFY) <b>Assistant</b>		MEDICAL EXAMINER DATE SIGNED <b>9/9/87</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Mario F. Golle, Jr., M.D.</b>		ADDRESS <b>111 Penn St., Balto., Md. 21201</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>12 Sept. 87</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Meadowridge Mem. Fk.</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Elkridge Howard MD.</b>	24. FUNERAL DIRECTOR NAME ADDRESS <b>John Dallas Slack # ADDRESS SLACK FUNERAL HOME</b>	
25a. DATE REC'D. BY REGISTRAR <b>SEP 18 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davis</b>			

**DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201**

07/84  
25M

DHMH - 17  
VR A15 ME (5))

080525 SEP 18 81

TO: MR. J. R. ...

...

...

...

FROM: MR. J. R. ...

SUBJECT: ...

...

...

...

...

...

...

...

...

067786 OCT-7 87

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26660

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Sadie Stanton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>09 -24- 87</b>		2b. HOUR <b>8:00P M</b>		
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>07 - 26 - 00</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Howard County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Woodbine</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1975 Daisy Road</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>Woodbine</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>1975 Daisy Road 21797</b>		14. FATHER'S NAME FIRST MIDDLE LAST <b>John Wesley Dorsey</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nellie Fisher</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-30-4540</b>		17. INFORMANT <b>Mildred Snowden</b>		17b. ADDRESS <b>1975 Daisy Road Woodbine, MD 21797</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Constrictive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/19/87</b> to <b>9/24/87</b> , that (I) (we) last saw the deceased alive on <b>7/31/87</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. We viewed the body after death.							
22b. SIGNATURE <b>John G. Lodmell</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>9/25/87</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN G LODMELL, M.D.</b>				22e. ADDRESS <b>2901 Olney-Sandy Spring Rd. Olney, Md. 20832</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>09-29-87</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Daisy UMC Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodbine Howard MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>HAIGHT FUNERAL HOME SYKESVILLE, MD 21784</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 06 1987</b>		25b. REGISTRAR'S SIGNATURE <b>Antonia Scivone-Pandora</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

067750 Oct 781

02225

WILSON

COX COTTON FIELD

2001 line - andy spring no. 01001

JOHN O. ROBERTS, R.I.



064784 SEP-4-87

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2, and 3 and file them in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

26661

1. DECEASED NAME (TYPE OR PRINT) JANET KAY TOTTEN			2a. DATE OF DEATH MONTH DAY YEAR SEPTEMBER 1, 1987		2b. HOUR 2:35pm
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 6, 1901	6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HOWARD COUNTY MD.		
10. CITY OR TOWN OF DEATH COLUMBIA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LORIEN NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. STATE MARYLAND		13b. COUNTY HOWARD	13c. CITY OR TOWN COLUMBIA	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 6308 SUN HIGH PLACE 21045
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT H KAY		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE TALMADGE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 090-03-5888	17. INFORMANT ROBERT TOTTEN		ADDRESS SAME AS # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>URINARY TRACT INFECTION</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-31</u> , 19 <u>87</u> , to <u>8-31</u> , 19 <u>87</u> , that (I) (we) lost saw the deceased alive on <u>8-31</u> , 19 <u>87</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Krishna P. Kumar</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 9-2-87
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR KRISHNA KUMAR			22e. ADDRESS 21044 10802 HICKORY RIDGE ROAD COLUMBIA MD.		
23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL	23b. DATE 9-4-87	23c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE ARLINGTON VIRGINIA	
24. FUNERAL DIRECTOR LEROI M. & RUSSELL C. WITZKE FUNERAL HOMES P.A. 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045			25a. DATE REC'D. BY REGISTRAR SEP 03 1987		



084584 SEP-4-84

SEP 03 1984

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Mary E. Tugwell				SEPTEMBER 3, 1987				5:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH 7 DAY 19 YEAR 34		53 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WASHINGTON, D.C.		U.S.A.				HOWARD COUNTY MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Columbia		Howard County General		OWNER		RETAIL - VIDEO			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		QUEEN ANNE		Stevensville				BAY CITY BOX 28-6 21666	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		NO		212-32-9505		WILLIAM TUGWELL SAME AS # 13	
LEROY CHARLES HUGHES		EVELYN MAE RICHARDSON							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		CARDIORESPIRATORY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(b)		ARTERIOSCLEROTIC VASCULAR DISEASE					
		(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:		CARCINOMA OF COLON METASTATIC							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sep 3, 19 87, to Sep 3, 19 87, that (I) (we) last saw the deceased alive on Sep 3, 19 87, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
		Levan Kuck		MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		HOWARD CO. GEN HOSP					
LEVAN KUCK		COLUMBIA MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		9/5/87		WOODLAWN		WOODLAWN MARYLAND			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
LEROY M. & RUSSELL WITZKE FUNERAL HOMES P.A.		SEP 9 1987		Julia Tindall-Rudman					
1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228									

062164 SEP 10 87

12-20-87  
COLUMBIA  
FIELD

SEP 10 1987

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE-MARYLAND 21201

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be completed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 21 is marked **Yes**, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

88

DHMH - 16 60M 7/84  
(VRA 15, 4)

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE OF DEATH		MONTH YEAR		3. HOUR	
FRANCES S. WOODS				SEPT. 4. 1987		8:30 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))		7. IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH DAY YEAR SEPT. 25 1915		71 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
WISCONSIN		U.S.A.				HOWARD MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
HIGHLAND		7335 MINK HOLLOW ROAD				TEACHER		EDUCATION	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS)					13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS / ZIP CODE		
13a. STATE COUNTY CITY OR TOWN MD. HOWARD HIGHLAND					YES <input type="checkbox"/> NO <input type="checkbox"/>		7335 MINK HOLLOW ROAD 20777		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST MILFORD SUMMERTON				FIRST MIDDLE LAST ADA JUDD					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
NO			215-38-3931		LEONARD I. WOODS- 7335 MINK HOLLOW RD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic endometrial carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from 19 <u>86</u> to 19 <u>87</u> that (I) (we) last saw the deceased alive on <u>9/4</u> 19 <u>87</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22a. SIGNATURE				DEGREE		22b. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
John R. Melnick				MD				9/5/87	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
John Melnick				911 Russell Ave. Gaithersburg, Md 20878					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
BURIAL		SEPT. 6. 1987		Grady Washington Cemetery		Adelphi P.A. MD			
24. FUNERAL DIRECTOR NAME				ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John J. Summerton				254 Carroll St. N.W.		SEP 8 - 1987		Julia Davidson-Randall	

002048-369-831